Within corporate limits DR. SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01200

177

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: ALLEGANY · STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND · COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND · LENGTH OF STAY (in this place): 7 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location): 121 N. MECHANIC ST.,

3. NAME OF DECEASED (Type or Print): (First) CHRIST (Middle) Crescenzo (Last) AVOLIO			4. DATE OF DEATH (Month) FEB. (Day) 14, (Year) 19 49	
5. SEX: male	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: Dec. 24, 1876	9. AGE last birthday: 72 yrs. · If under 1 year: Months · Days · If under 24 hrs.: Hours · Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoemaker	10b. KIND OF BUSINESS OR INDUSTRY: Shoemaking	11. BIRTHPLACE (State or foreign country): ITALY		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ANTONY AVOLIO		14. MOTHER'S MAIDEN NAME: CESIDIA [redacted] Vitucci		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	3 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma Prostate	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/12, 1949, to 2/14, 1949, that I last saw the deceased alive on 2/14, 1949, and that death occurred at 11:45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George M Symons	M.D	12 & Union St Cumb. Md.	2/14/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-17-49	S.S. Peter & Paul	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 17, 1949	Winter R. Mantz M.D.	Charles L. George	Cumberland, Md.

RECEIVED
FEB 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

01201

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 55 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Fairview Ave

3. NAME OF DECEASED (Type or Print): (First) Preston (Middle) Greenberry (Last) Biller

4. DATE OF DEATH: (Month) 2 (Day) 12 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 23 1882

9. AGE last birthday: 66 yrs. If under 1 year: Months 6 Days 19 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter & Contractor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Summitt Point, W. Va.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Jacob W. Biller

14. MOTHER'S MAIDEN NAME: Henrietta Frances (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-16-4415

17. INFORMANT: James Biller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	15 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension Heart Disease	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 28 1949, to Feb 12 1949, that I last saw the deceased alive on Feb 11, 1949, and that death occurred at 6.20a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): A. Allen G. Murray M.D. ADDRESS: Cumberland Md DATE SIGNED: Feb 12 49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Feb 15 1949
NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park
LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Feb. 14, 1949
REGISTRAR'S SIGNATURE: Wenster K. Krantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight
ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. S.

Within corporate limits HODGES

01202

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

761.5

CERTIFICATE OF DEATH

160C

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 5 HRS. 50 MIN.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location) 221 S. MECHANIC STREET

3. NAME OF DECEASED (Type or Print) (First) ~~BABY BOY~~ (Middle) GRANT (Last) BITTINGER

4. DATE OF DEATH (Month) (Day) (Year) February 20 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
MALE	WHITE	Single	2/19/49	yrs.		5 / 50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	None	Cumberland, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harold G. Bittinger	JANICE P. PALSGRAAF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
	None	Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity - ~~anoxemia~~ anoxemia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Central Placenta Praevia

(c)

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Low flap Caesarian (Massive Preop. Hemorrhage)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2/19/49	Central Placenta Praevia	Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
NO	—	—

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ ~~Not While~~ At work ☐	HOW DID INJURY OCCUR?
— m.		—

22. I hereby certify that I attended the deceased from 2/19/49 to 2/20, 1949 that I last saw the deceased alive on 2/20/49 and that death occurred at 5 45A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W Royce Hodges, M.D.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
CREMATION	FEB. 21, 1949	Memorial Hosp.	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 21, 1949	Winter R. Frantz, M.D.	Memorial Hosp.	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 2 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 85 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Co Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 434 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Martha	F.	Bland	Feb.	28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	June 27 1863	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Cumberland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Geo. J Flurshutz	Sophia Ebert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.		None.	Mrs John J Biggs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocardial failure	6 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	2 Mos
	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1948, to Feb 28, 1949, that I last saw the deceased alive on Feb 26, 1949, and that death occurred at 12 30 p. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M. D.	110 S. Centre St. Cumberland, Md.	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar 2 49	St Lukes Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 1, 1949	Walter L. Trautz, M.D.	Louis Stein Inc.	Cumberland

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MAR 7 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

151
46

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Franklin
LENGTH OF STAY (in this place): 40 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Franklin
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Margaret	Rebecca	Blizzard	Feb.	21	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Widow	Sept. 15, 1868	80 yrs.	5	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House-Wife	Own-Home	Petersburg W. Va.	U.S.

13. FATHER'S NAME: Saul Van Meter

14. MOTHER'S MAIDEN NAME: Belinda Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
XXX	XXX		Enock Blizzard

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcenoma of Stomach — 3 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cachexia
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 5 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐	Not While At Work ☐	HOW DID INJURY OCCUR?
			m.			

22. I hereby certify that I attended the deceased from Dec 1st, 1948, to Feb 21, 1949, that I last saw the deceased alive on Feb 20, 1949 and that death occurred at 7:55 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jane K. Gallahan	M.D.	Piedmont W.Va.	2/24/49

23. BURIAL, CREMATION REMOVAL. (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 23, 1949	Philos Cemetery	Westernport	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 23/49	[illegible]	E.S. Boal	Westernport, Md.

VS. A15

RECEIVED
FEB 24 1949
BUREAU V. S.

Within corporate limits

DR. DURRETT

EVIDENCE FOR REARRANGEMENT OF # 18 IS ON: FILM # G119 - 4-1-49 A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

193
54 b

01205

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: ALLEG
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 20 HRS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCOOLE ~~MD~~
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location): R. F. D. #2

3. NAME OF DECEASED (Type or Print) (First) STANLEY	(Middle) DIXON	(Last) BONNER	4. DATE OF DEATH (Month) FEB.	(Day) 18	(Year) 1949
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED	8. DATE OF BIRTH: FEB 28.1902	9. AGE last birthday: 46 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER	10b. KIND OF BUSINESS OR INDUSTRY: BUILDING Houses	11. BIRTHPLACE (State or foreign country): W. VA	12. CITIZEN OF WHAT COUNTRY? AMERICA		
13. FATHER'S NAME: OLIVER BONNER		14. MOTHER'S MAIDEN NAME: *~~ROY~~*DELLA Roy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Memorial Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Necrosis of brain tissue [3/31/49 abc]

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Brain tumor in medulla (Glioma)	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) II Cerebral edema (marked)	
	(c) II Subarachnoid hemorrhage (slight)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. II Bronchopneumonia — about 2 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Feb. 18, 1949, ~~to~~ ~~19~~, that I last saw the deceased ~~alive~~ Dead on Feb. 18, 1949, and that death occurred at 12noon m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H. V. Deming M.D.	Cumberland Md.	Feb. 18-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Feb. 21, 1949	NAME OF CEMETERY OR CREMATORY: Davis	LOCATION (City, town, or county) (State): Piedmont, West Virginia
DATE REC'D BY LOCAL REG.: Feb. 20, 1949	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: E. S. Boal	ADDRESS: Westernport

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAR 2 1949
BUREAU V. A.

Within corporate limit

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

01206

CERTIFICATE OF DEATH

93d Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 45 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 622 Washington St.	STREET ADDRESS (If rural, give location) 622 Washington St.

3. NAME OF DECEASED (Type or Print) (First) Charlotte (Middle) Wilson (Last) Bowie

4. DATE OF DEATH (Month) (Day) (Year) February 24 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Widowed	June 15, 1869	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at Home	North Bend, Wis.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert D. Wilson	Margaret Penman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	—	213-22-3338	Douglas L. Bowie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	1½ hours.
Antecedent cause(s)	(b) Arterio-sclerotic & Coronary Heart disease.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 18 June, 1948, to 24 Feb, 1949, that I last saw the deceased alive on 24 Feb., 1949, and that death occurred at 11 45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Jr. Alfred Van Ormer	531 Louisiana Ave. Cumberland	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 27, '49	Rose Hill Cem.	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 25, 1949	Winter R. Frantz, M.D.	Louis Stein Inc.	Cumberland Md

RECEIVED
MAR 2 1949
BUREAU V. S.

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01207

451
30d

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital	STREET ADDRESS (If rural, give location): 439 Walnut St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Reed	Brown	Feb.	24	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
male	white	Widower	Jan. 27-1893	56 yrs.	0	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner & Construction	Coal mine	Lonaconing Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Mc Donald	Bessie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	215-07-3954	James Walker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	about 2
Antecedent cause(s)	Dessecting aneurysm of the aorta, also had a	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) large (thoracic) aneurysm.	hours
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I ~~attended~~ saw the deceased from Feb. 24, 1949, to ----------, 19....., that I last saw the deceased alive on Feb. 24, 1949, and that death occurred at 8.20 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.		Cumberland Md.	2-25-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 27 1949	Hamill Cemetery	Kitzmiller	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 26, 1949	Walter R. Rauh M.D. Deputy Medical Examiner - Allegany Co.	William H. Kight	Cumberland, Md

VS. A15

RECEIVED
MAR 2 1949
BUREAU T. I.

01208

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2
932

Evidence for change of birth date shown on:

FILM NO. G 119 FEB 21 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 W. Main

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 17 W. Main St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Thomas	Dawson	Brown	2	5	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Feb 29 1865	83 yrs.	11	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Miner	Coal Mines	Moore Fork, W. Va	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Thurston Brown	Lebah V. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Mrs J. H. Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chr Myocarditis — Interval between onset and death: Several months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct, 1948, to Feb 5, 1949, that I last saw the deceased alive on Jan 27, 1949, and that death occurred at 10:05 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. McLane MD		Frostburg Md	Feb 7 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/8/49	Allegany	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-8-49	Mrs. Lavey H. Roe	Jacob Hafer	

VS. A15

RECEIVED
FEB 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 44 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 306 Magruder St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 306 Magruder St

3. NAME OF DECEASED (Type or Print): (First) Vernon (Middle) Wells (Last) Bullett

4. DATE OF DEATH: (Month) Feb. (Day) 28 (Year) 1949

5. SEX: male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: Oct. 29-1892

9. AGE last birthday: 56 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butler

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Paw Paw W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S/A

13. FATHER'S NAME: Frank Bullett

14. MOTHER'S MAIDEN NAME: Leah Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sister) Edmonia Bullett

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic myocarditis — Interval between onset and death: about 6 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased from Feb. 28 1949 to ---------, 19--, that I last saw the deceased ~~alive~~ Dead on 2-28, 1949 and that death occurred at 8.30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H.V.Deming M.D. N.V. Deming M.D.

ADDRESS: Cumberland Md.

DATE SIGNED: Feb. 28-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: March 3 49

NAME OF CEMETERY OR CREMATORY: Camp Hill Cem.

LOCATION (City, town, or county) (State): Paw Paw W. Va.

DATE REC'D BY LOCAL REG.: March 1, 1949

REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Sons

ADDRESS: Cumberland

Deputy Medical Examiner - Allegany Co

VS. A15

RECEIVED
MAR 7 1949
BUREAU V. S.

Within corporate limits

Shirley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

151
146 lbs

01210

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY Allegany — MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS 616 Niagara St.	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland — COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS (If rural, give location) 616 Niagara St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Kenneth	Buskirk	Feb.	4	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	June 17, 1911	37 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Yard Master	R.R.	Davis, W.Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James M. Buskirk	Lulu V. Cubbage

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	11	220-10-9114	Mrs. Edith Buskirk

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Stomach — Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ____, 19____, to Feb. 4, 1949, that I last saw the deceased alive on Feb. 3, 1949, and that death occurred at ____ m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Blone M. Schindler	M.D.	Cumberland, Md.	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 6, 1949	Rose Hill Cem.	Thomas, W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 6, 1949	Winter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

VS. A15

RECEIVED
FEB 15 1949
BUREAU T. S.

Within corporate limits

Dr. W. F. Wims

01211

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

450.0

97

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND,
MARYLAND
LENGTH OF STAY (in this place): 103 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCOOLE, MD.
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) ~~TONY~~ Antonio (Middle) . (Last) CHUCCI

4. DATE OF DEATH: (Month) FEBRUARY (Day) 17 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: JUNE 16 1863

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: FRANCISCO CHUCCI

14. MOTHER'S MAIDEN NAME: MARGESP BENEDICTO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Benign hypertrophy prostate

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-6-48, to 2-17-49, that I last saw the deceased alive on 2-16-1949, and that death occurred at 10 am m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Howard R. Folson, MD

ADDRESS:

DATE SIGNED: 2-17-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 2-19-49

NAME OF CEMETERY OR CREMATORY: Queens Point

LOCATION (City, town, or county): Keyser (State): W Va

DATE REC'D BY LOCAL REG.: Feb. 19, 1949

REGISTRAR'S SIGNATURE: Winters R. Lantz, M.D.

24. FUNERAL DIRECTOR: Thomas R Smith Jr

ADDRESS: Keyser W Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. C

Within Corporate limits

Evidence for change in birth Date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01212

41
932

FILM No. G 120 MAY 5 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: West Virginia — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 5 Days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgeley
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 135 Main Street ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Forrest		Clark	February	1	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	11/15/1905	43 yrs.	2		16	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meat Cutter	Meat Market	Woodland, Md Allegany Co	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Clark	Elsie Duckworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	2 16-05-5824	William Clark

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Rheumatic Cardiovascular disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec., 19 49, to 2/1, 19 49, that I last saw the deceased alive on 2/1, 19 49, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
George M. Simon M.D	12 Union St. Cumberland Md.	2/4/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/3/49	Hill Crest Burial Park	Cumberland,	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 2, 1949	Walter R. Frantz, M.D.	William H. Kight	Cumberland, Md

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. S.

01213

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

812.5
170C

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 31 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural, give location) 525 Eastern Ave.

3. NAME OF DECEASED (Type or Print)	(First) Edwin	(Middle) Russell	(Last) Coakley Jr.	4. DATE OF DEATH	(Month) Feb (Day) 4 (Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9/16/1917	9. AGE last birthday 31 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter Mechanic	10b. KIND OF BUSINESS OR INDUSTRY B & O. Railroad	11. BIRTHPLACE (State or foreign country) Cumberland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edwin R. Coakley Sr.	14. MOTHER'S MAIDEN NAME Viola Kirtley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 214-07-6594	17. INFORMANT Mrs Edwin R. Coakley Sr.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intracranial Hemorrhage	about
Antecedent cause(s)	due to a stellate fracture at vault of skull	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Riding down hill on a sled and hit an	6 hours
	(c) automobile	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway Baltimore Ave	(CITY OR TOWN) Cumberland	(COUNTY) Allegany	(STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Feb.3/49-955P.m.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR? Riding down hill on a sled and hit an automobile.		

22. I hereby certify that I ~~attended~~ saw the deceased from Feb.4, 1949, to ---------, 19---, that I last saw the deceased Dead ~~alive~~ on Feb.4, 1949, and that death occurred at 3.45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H. V. Deming M.D.	Cumberland Md.	Feb.4-1949

Deputy Medical Examiner - Allegany Co.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/6/49	NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	LOCATION (City, town, or county) Cumberland	(State) Md.
DATE REC'D BY LOCAL REG. Feb. 6, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hafer	ADDRESS Cumberland Md.	

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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RECEIVED
FEB 15 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

01214

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 6 weeks; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. Va; COUNTY Mineral; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgeley; STREET ADDRESS (If rural, give location) 5 Blocher St. ✓

3. NAME OF DECEASED (Type or Print): (First) Rosie (Middle) (Last) Coffman

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 9, 1899

9. AGE last birthday: 50 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pendleton Co. W. Va

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ann Helmick

14. MOTHER'S MAIDEN NAME: Alice Wilfong

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Stella Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Hepatitis — Interval Between Onset and Death: One Month

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1949, to 2-16, 1949, that I last saw the deceased alive on 2-16, 1949, and that death occurred at 7:11 A m., from the causes and on the date stated above.

SIGNATURE: J. Johnson (Degree or title) M.D. ADDRESS: Cumberland, Md. DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Feb 19, 1949

NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 19, 1949

REGISTRAR'S SIGNATURE: Winter K. Lantz, M.D.

24. FUNERAL DIRECTOR: John J Hafer ADDRESS: Cumberland, Md.

VS-A15

Johnson

RECEIVED
FEB 22 1949
BUREAU Y. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

420.1 94a

01215

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 15 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 491 Baltimore Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 491 Baltimore Ave

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Evelyn (Last) Constable

4. DATE OF DEATH (Month) Feb. (Day) 12 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 9 1903
9. AGE last birthday 45 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ridgeley W. Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm Allen King
14. MOTHER'S MAIDEN NAME Etta Amelia Durr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 217-10-9176
17. INFORMANT Harry F. Constable

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Coronary Occlusion	1 hour
Antecedent cause(s)	(b) Coronary Heart Disease	2 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Aug, 1949, to 12 Feb, 1949 that I last saw the deceased alive on 12 Feb, 1949 and that death occurred at 12 45 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. Alfred Van Ormer Cumberland, Md 12 Feb. 46

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 14 '49
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Feb. 14, 1949
REGISTRAR'S SIGNATURE Winter R. Lautz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS "

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. S.

Within corporate limits: DR. W. F. WILLIAMS

U1216

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

430.0

CERTIFICATE OF DEATH

91a

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. VA. COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 7 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GREEN SPRING
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print)	(First) HUMBIRD	(Middle) P	(Last) DAVIS	4. DATE OF DEATH	(Month) FEB.	(Day) 22	(Year) 1949
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH Dec. 27, 1895	9. AGE last birthday 53 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Wood Preserving Co	11. BIRTHPLACE (State or foreign country) Hampshire County, West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME HENRY DAVIS		14. MOTHER'S MAIDEN NAME Catherine Moreland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 232-10-5635	17. INFORMANT MEMORIAL HOSPITAL					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Bacterial Endocarditis	About
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Brain Abscess (multiple)	2 wks.
	(c) Infarcts in spleen + lungs.	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2.15., 1949, to 2.22., 1949, that I last saw the deceased alive on 2.22., 1949, and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. F. Williams	M.D.	Cumberland Md.	2/23/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/26/49	Hans Run Cem	Fort Ashby, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/24/49	Winter R. Frantz M.D.	H. C. Ruckman	Romney W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAR 2 1948
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01217

4201

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 45 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 451 Columbia St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 451 Columbia St.

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) H. (Last) Dennison

4. DATE OF DEATH: (Month) Feb. (Day) 5 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Jan.3-1904

9. AGE last birthday: 45 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Sign & House

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Dennison

14. MOTHER'S MAIDEN NAME: Chattie Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-7892

17. INFORMANT: wife) Mrs. Sally Dennison

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s)	coronary sclerosis	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased from Feb. 5, 1949 to -------, 19--, that I last saw the deceased ~~Dead~~ alive on Feb. 5, 1949 and that death occurred at about 6.25 P. m., from the causes and on the date stated above.

SIGNATURE: H.V. Deming M.D. H. V. Deming M.D.
(Degree or title)
ADDRESS: Cumberland Md.
DATE SIGNED: Feb. 5 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 2/8/49
NAME OF CEMETERY OR CREMATORY: Bier Cemetery
LOCATION (City, town, or county) (State): Rawlings Maryland

DATE REC'D BY LOCAL REG.: Feb. 7, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
Deputy Medical Examiner - Allegany Co.

24. FUNERAL DIRECTOR: William H. Kight
ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R D #4 Uhl Highway

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
STREET ADDRESS (If rural, give location): R D #4 Uhl Hwy.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Francis (Last) Diggs

4. DATE OF DEATH: (Month) Feb. (Day) 27 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov 22 1884

9. AGE last birthday: 64 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worker

10b. KIND OF BUSINESS OR INDUSTRY: Rail way

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Diggs

14. MOTHER'S MAIDEN NAME: Katherine Hammersmith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Morris L. Diggs (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Several Years.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Myocardial Degeneration

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 13, 1949, to Feb. 27, 1949, that I last saw the deceased alive on Feb. 23, 1949, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE: W. F. Williams — (Degree or title): M.D. — ADDRESS: Cumberland — DATE SIGNED: Md.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Mar 3 '49 — NAME OF CEMETERY OR CREMATORY: St Peter & Paul's Cem — LOCATION (City, town, or county): Cumberland — (State): Md.

DATE REC'D BY LOCAL REG.: March 1, 1949 — REGISTRAR'S SIGNATURE: Winter K. Trautz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

RECEIVED
MAR 3 1949
BUREAU V. S.

01219

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place) 13 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Island St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Island Street

3. NAME OF DECEASED (Type or Print) (First) Maria (Middle) — (Last) Dodds

4. DATE OF DEATH (Month) Feb (Day) 12 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 6 1883
9. AGE last birthday 65 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Midland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Eli Pendleberry
14. MOTHER'S MAIDEN NAME Catherine Lloyd.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs. Sam Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

INTERVAL BETWEEN ONSET AND DEATH: 1 day

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Paul Eugene Frye (Degree or title) M.D. ADDRESS Lonaconing Md DATE SIGNED 2/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 15 49
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) Lonaconing (State) Md.

DATE REC'D BY LOCAL REG. 2/16/49
REGISTRAR'S SIGNATURE Jannette M Frol
24. FUNERAL DIRECTOR Jn. Eichhorn, ADDRESS Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 28 1949
BUREAU U. S.

Within corporate limits ✓ DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 206 PARK ST.,

3. NAME OF DECEASED (Type or Print): (First) LAVINIA (Middle) (Last) DOW

4. DATE OF DEATH: (Month) Feb (Day) 3 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: Oct. 10, 1875

9. AGE last birthday: 73 yrs. | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN D. WEGMAN

14. MOTHER'S MAIDEN NAME: NANCY HUGHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemiplegia — Interval between onset and death: 30 hrs

Antecedent cause(s) Arteriosclerosis — ?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: None — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): None m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 3, 1949, to Feb. 4, 1949, that I last saw the deceased alive on Feb. 4, 1949, and that death occurred at 10 00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. A. Hodges — ADDRESS Cumberland, Md. — DATE SIGNED 2/5/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE 2-7-49 — NAME OF CEMETERY OR CREMATORY Rose Hill — LOCATION (City, town, or county) (State) Cumberland - Md

DATE REC'D BY LOCAL REG. Feb. 5, 1949 — REGISTRAR'S SIGNATURE Winter K. Frantz, M.D. — 24. FUNERAL DIRECTOR Charles L. George — ADDRESS Cumberland, Md.

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01221

331

830

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Church Street	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) Church Street
3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Simpson (Last) Doyle	4. DATE OF DEATH: (Month) Feb. (Day) 3rd (Year) 1949
5. SEX: Female	6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: April 2 1863
9. AGE last birthday: 85 yrs.	If under 1 year: Months. / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY: At her home
11. BIRTHPLACE (State or foreign country): Yorkshire, England	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unknown	14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No; (If year, give war or dates of service) —	16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert Doyle	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s) Cerebral Hemorrhage 6 months ago

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) None

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒	
21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 24, 1949, to Feb 3, 1949, that I last saw the deceased alive on Jan 29, 1949, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Henry W. Hodgson M D — ADDRESS: R 1 Cumberland Md. — DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE: Feb. 6, 1949	NAME OF CEMETERY OR CREMATORY: Old Coney Cemetery	LOCATION (City, town, or county) (State): Lonaconing, Allegany Md	
DATE REC'D BY LOCAL REG.: Feb 6 1949	REGISTRAR'S SIGNATURE: Jeannette M Boal	24. FUNERAL DIRECTOR: W. E. Eichhorn	ADDRESS: Lonaconing	

VS. A15

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FEB 10 1949
BUREAU OF S.

Within corporate limits

01222

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

61 Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 78 W. College Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Margaret	Elizabeth	Duckworth	Feb.	2	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	1/6/1882	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	none	Clarksburg, W. Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John C. O'Day	Mary Haley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Alma Duckworth

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	2 Feb 49
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes mellitus	?
	(c) Hemorrhoids adenocarcinoma	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Jan 24, 1949	1. Brown cyst (Rt) 2. Chronic D.B. with Stones	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug 11, 1948, to Feb 2, 1949, that I last saw the deceased alive on Feb. 1, 1949, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. Alfred Vrn	Mrs. M. D	531 Lonsdon ave. Cumberland, Md	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-8-1949	St. Michaels Cem.	Frostburg	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 6, 1949	Walter K. Mantz, M.D.	Jacob Hafer	Frostburg, Md.

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DR. R. WILLIAMS

01223

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

5921
131

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 20 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location) 5 GRAND AVE.,

3. NAME OF DECEASED (Type or Print)	(First) ALLEN	(Middle) E.	(Last) DURST	4. DATE OF DEATH	(Month) FEB.	(Day) 19	(Year) 1949
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 6 1894	9. AGE last birthday 54 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER	10b. KIND OF BUSINESS OR INDUSTRY B & O RAILROAD	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME RICHARD A. DURST	14. MOTHER'S MAIDEN NAME MARY ~~CATON~~ Caton						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 705-14-0635	17. INFORMANT MEMORIAL HOSPITAL					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	24 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Uremia	10 yrs.
	(c) Chr Nephritis	15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/2/49 19....., to 2/19/49, that I last saw the deceased alive on 2/19/49, 19....., and that death occurred at 4a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Richard J. Williams	M.D.	Cumberland, Md	2/20/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 21, 1949	Rose Hill Cemetery	Cumberland,	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 21, 1949	Winter R. Sautz, M.D.	John J. Hofer	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

592

CERTIFICATE OF DEATH

131a

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) [illegible]	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Co. Infirmary	STREET ADDRESS (If rural, give location) 115 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Francis (Last) Finan			4. DATE OF DEATH (Month) Feb (Day) 5 (Year) 1949		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov 9 1864	9. AGE last birthday 84 yrs.	If under 1 year Months. Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman, Retired	10b. KIND OF BUSINESS OR INDUSTRY Wholesale grocery		11. BIRTHPLACE (State or foreign country) Fall River, Mass	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Patrick Finan			14. MOTHER'S MAIDEN NAME Catherine Noonan.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Bart J Finan		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremic Poisoning	5 wks
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic interstitial nephritis	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1946, to Feb 5, 1949, that I last saw the deceased alive on Feb 2, 1949, and that death occurred at 3 15 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 8 49	St Patricks Cem	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 8, 1949	Winter R. Frantz M.D.	Louis Stein Inc	" "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 171 Polk St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 171 Polk St.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Robert	Jesse	Fink	Feb.	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Write)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days.	If under 24 hrs.: Hours	Min.
Male	White	Married	Jan 24 1873	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trainman	B & O Ry.	Penna	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Valentine Fink	Susan Fluke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
—	—	705-09-4189	Robert N. Fink

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Colon

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

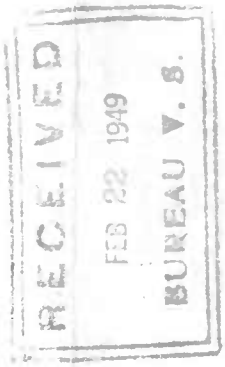
22. I hereby certify that I attended the deceased from 1/15/49, 19..., to 2/13/49, 19..., that I last saw the deceased alive on 2/12/49, 19..., and that death occurred at 12 17 AM m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E. H. Williams	MD	Cumberland	2/15/49

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 16 '49	Rose Hill Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 16, 1949	Walter R. Bantz, M.D.	Louis Stein Inc	Cumberland

Dr Richard Williams



Within corporate limits DR. W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01226

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469

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
MARYLAND
LENGTH OF STAY (in this place): 12 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural give location): 127 PENNSYLVANIA AVE.,

3. NAME OF DECEASED (Type or Print): (First) RUTH (Middle) N. (Last) FISHER

4. DATE OF DEATH: (Month) FEB. (Day) 26 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: SEPT. 7, 1888

9. AGE last birthday: 60 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MASSACHUSETTS

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: CHARLES D. STOWERS

14. MOTHER'S MAIDEN NAME: HENRIETTA MILLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Head of Pancreas Metastasis — Interval Between Onset and Death:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Biliary Sclerosis
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4. 9., 19 48 to 2. 26, 19 49, that I last saw the deceased alive on 2. 25., 19 49, and that death occurred at 1:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm. F. Williams M.D. ADDRESS: Cumberland DATE SIGNED: 2/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 3-1-49
NAME OF CEMETERY OR CREMATORY: Queen mount
LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Feb. 28, 1949
REGISTRAR'S SIGNATURE: Walter R. Krantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Scarpelli 108 Virginia Ave Cumberland Md

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MAR 7 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01227

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 505 Columbia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 505 Columbia Ave.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Willow Viola Boor Frantz

4. DATE OF DEATH (Month) (Day) (Year): Feb. 7 1949

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Oct.5-1890
9. AGE last birthday: 58 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles G.Boor
14. MOTHER'S MAIDEN NAME: Jane Bucy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Guy Frantz-(Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — at once

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) coronary sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ 2-7-, 1949, to ~~19~~, that I last saw the deceased ~~alive~~ Dead on 2-7, 1949, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE: H.V.Deming M.D. H.V. Deming Md (Degree or title) — ADDRESS: Cumberland Md. — DATE SIGNED: Feb. 7- 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Feb.10 1949
NAME OF CEMETERY OR CREMATORY: Rose Hill Cem Crypt
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 9, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

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FEB 15 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

01228

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH 87

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland, Rural; STREET ADDRESS (If rural, give location) Bowman's Addition, R.F.D. #3

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clarence		Fresh	February	10	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
M	White	Single	1907	42 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Somerset Co. Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John M. Fresh	Margaret Hedrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Fred Fresh

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Myocardial Failure	6 hrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebrospastic from birth	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 1946, 19..., to Feb. 10, 1949, that I last saw the deceased alive on Feb. 8, 1949, and that death occurred at 1:20 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S Centre St.	Cumberland Md 2-12-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 12, 1949	Mt. Herman Cemetery	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 12, 1949	Winter R. Trautz, M.D.	John J. Hofer	Cumberland, Md.

VS. A15

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FEB 15 1949
BUREAU V. S.

Please call 65
when signed.
Thank you.

Outside of City limits

01229

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

916.0 191

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bowmans Addition | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 3 Cumberland Md

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bowmans Addition near Cumberland.
STREET ADDRESS (If rural give location) Route 3 Cumberland, Md.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Timothy (Last) Fulks
4. DATE OF DEATH: (Month) Feb (Day) 15 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: Aug 12, 1927
9. AGE last birthday: 21 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: Watch Making
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Bruce C. Fulks
14. MOTHER'S MAIDEN NAME: Ada H. Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles Faulkner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Suffocation & 1st, 2nd. & 3rd. degree burns	about 5
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) House caught fire due to overheated	minutes
	(c) kerosene oil heater	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home
(CITY OR TOWN): Bowman's Addition Cumberland (COUNTY): Allegany (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Feb. 15/49 11:45 p. m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? House caught fire due to overheated kerosene oil heater while he was asleep.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Feb 16, 1949, to ----------, 19---, that I last saw the deceased alive on Feb. 16, 1949, and that death occurred at 11.45P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	Feb. 16-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/18/49	Oak Grove Cemetery	Genoa W Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Feb 18, 1949	Winter K. Hartz, M.D.	John J. Hafer Cumberland Md

VS. A15

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FEB 22 1949
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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.1 94 01230

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

7

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Marylsnd; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 29 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 433 Bond Street	STREET ADDRESS (If rural give location): 433 Bond Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Virginia	Belle	Gracie	Feb	28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Married	Feb 14 [illegible] 1894	55 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Phillipi, Barbour Co, W. Va.	US.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Delbert Campbell	Ida Nutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or uoknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	—	John W. Gracie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	15 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) auricular fibrillation, Enlarged arteriosclerosis,	1-2 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 1, 1948, to Feb. 25, 1949, that I last saw the deceased alive on Feb. 25, 1949, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Blaine M. Schindler	M.D.	41 Greene St., Cumberland, Md.	March 1, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	March 5 1949	Zion Memorial Burial Park	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 2, 1949	Winter R. Lantz, M.D.	William H. Kight	Cumberland, Md.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01231

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
MARYLAND — LENGTH OF STAY (in this place): 8 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 222 Philos Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location): 222 Philos Ave.

3. NAME OF DECEASED (Type or Print): (First) Harold (Middle) W. (Last) Green

4. DATE OF DEATH: (Month) Feb. (Day) 3 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: July12-48

9. AGE last birthday: ------ yrs. If under 1 year: Months 8 | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Keyser W.Va. Hospital

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ollie Green

14. MOTHER'S MAIDEN NAME: Nettie Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Parents

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Virus Pneumonia, bilateral	about 1
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pylitis & congestion of viscera.	week
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Feb. 3, 1949 to ---------, 19--, that I last saw the deceased alive on Feb. 3, 1949, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. Feb.3- 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 2/5/49 | NAME OF CEMETERY OR CREMATORY: Philos Cem | LOCATION (City, town, or county) (State): Westernport, Md

DATE REC'D BY LOCAL REG. Feb 5 1949 | REGISTRAR'S SIGNATURE: [illegible] M.D. Deputy Medical Examiner - Allegany Co.

24. FUNERAL DIRECTOR: E. L. Boal | ADDRESS: Westernport, Md

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FEB 7 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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01232

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 20 N.Mechanic St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 810 Sylvan Ave.

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) D. (Last) Hagenbuch

4. DATE OF DEATH: (Month) Feb (Day) 20 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Marchll-1920

9. AGE last birthday: 28 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner of Restaruant

10b. KIND OF BUSINESS OR INDUSTRY: serving food

11. BIRTHPLACE (State or foreign country): Pittsburg Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert D.Hagenbuch

14. MOTHER'S MAIDEN NAME: Mildred Tepe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If year, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 172-14-6522

17. INFORMANT: Brother) John Hagenbuch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial hemorrhage — at once

Antecedent cause(s) (Congenital) aneurysm)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ruptured aneurysm in the Circle of Willis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Feb. 20, 19 49 ~~to~~ ....., 19..., that I last saw the deceased ~~alive~~ Dead on Feb. 20, 19 49 and that death occurred at 4.55 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H.V.Deming M.D. H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Feb. 21-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Buried — DATE: Feb. 23, 1949 — NAME OF CEMETERY OR CREMATORY: St. Marys Cem — LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: Feb. 23, 1949 — REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

Deputy Medical Examiner - Allegany Co.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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416
95b

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 2 wks.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg, Md.
STREET ADDRESS (If rural, give location): R. D. No. 2

3. NAME OF DECEASED (Type or Print): (First) Thomas Eugene (Middle) (Last) Harden

4. DATE OF DEATH: (Month) 2 (Day) 6 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 7-29-1944

9. AGE last birthday: 4 yrs. If under 1 year: Months. 6 Days 7 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg Miner's Hospital, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jesse E. Harden

14. MOTHER'S MAIDEN NAME: Beatrice M. Kendall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Jesse E. Harden

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Congestive Heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rheumatic Pericarditis

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 Feb, 1949, to 5 Feb, 1949 that I last saw the deceased alive on 5 Feb, 1949, and that death occurred at 12 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John B. Davis, M.D. ADDRESS: Frostburg, Md. DATE SIGNED: 2/7/49.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 2-8-1949
NAME OF CEMETERY OR CREMATORY: Porter's Cemetery
LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG. 2-7-49
REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer ADDRESS: Frostburg, Md.

VS. A15

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FEB 9 1949
BUREAU V. S.

01234

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
LENGTH OF STAY (In this place): 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: W.Va. — COUNTY: Tucker
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davis
STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Mary	Elizabeth	Harr		Feb.	3	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	If under 24 hrs. Days	Hours	Min.
Female	White	Widowed	Aug. 24, 1854	94 yrs.	5	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own-home	Taylor Co. W.Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Griffith	Matilda Griffith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		xxx —	Mrs. Dewey Borror

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Edema	1 Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic	1 Year
	(c) Malnutrition and Arteriosclerosis	1 Year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None	None	—	—	—

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐	Not While At work ☐	HOW DID INJURY OCCUR?
—	—	—	m.			—

22. I hereby certify that I attended the deceased from Jan. 31, 1949, to Feb. 3, 1949, that I last saw the deceased alive on Feb. 2, 1949, and that death occurred at 5:15 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul R. Wilson	M.D.	Piedmont, W.Va.	Feb. 4, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 6 1949	Harr Cem.	Davis, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4, 1949	[illegible] M.D.	Ellsworth E. Bird	

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FEB 7 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1 94a

01235

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 716 Maple St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 716 Maple St

3. NAME OF DECEASED (Type or Print): (First) Isiah (Middle) Jonathan (Last) Heare

4. DATE OF DEATH: (Month) Feb (Day) 7 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 8 1875

9. AGE last birthday: 73 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R Switchman

10b. KIND OF BUSINESS OR INDUSTRY: R.R (Retired)

11. BIRTHPLACE (State or foreign country): Kirby W. Va.

12. CITIZEN OF WHAT COUNTRY?: U S A.

13. FATHER'S NAME: Isiah Heare

14. MOTHER'S MAIDEN NAME: Ellen Lacy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 705-09-3675

17. INFORMANT: Miss Elsinor Heare

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: 8 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis — 5 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 19 48, to Feb 7, 19 49, that I last saw the deceased alive on Feb 6, 19 49 and that death occurred at 7 40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Clay S Lucas M D. ADDRESS: Cumberland DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Feb 9 49

NAME OF CEMETERY OR CREMATORY: Mt Zion Cem

LOCATION (City, town, or county) (State): Kirby, Hampshire Co W. Va

DATE REC'D BY LOCAL REG.: Feb. 9, 1949

REGISTRAR'S SIGNATURE: Winster R. Kantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Louis Stein Inc Cumberland

RECEIVED
FEB 15 1949
BUREAU V. S.

Within corporate limits Heller

M

01236

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331

CERTIFICATE OF DEATH

830 Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md. LENGTH OF STAY (in this place) 52 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 N. Lee Street	STREET ADDRESS (If rural, give location) 121 N. Lee Street

3. NAME OF DECEASED (Type or Print)	(First) Louis	(Middle) H	(Last) Heller	4. DATE OF DEATH	(Month) 2/21/49 (Day) (Year) 49
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 27, 1870	9. AGE last birthday 78 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY barber	11. BIRTHPLACE (State or foreign country) Stroudsburg, Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Heller	14. MOTHER'S MAIDEN NAME Caroline Evans				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mildred M. Heller 221 N. Lee St			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	72 hours
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arteria Sclerosis	?
	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) None	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/18, 1949, to 2/21, 1949, that I last saw the deceased alive on 2/21, 1949, and that death occurred at 8 a. m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) MD ADDRESS 140 Bedford St DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/23/49	NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	LOCATION (City, town, or county) (State) Cumberland, Maryland
DATE REC'D BY LOCAL REG. Feb. 23, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz MD	24. FUNERAL DIRECTOR John C. Wolfgang 125 S Liberty St.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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RECEIVED
MAR 2 1949
BUREAU V. S.

RECEIVED
MAR 2 1949
BUREAU V. S.

01237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

175
49a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 54 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 93 W. Main St.,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 93 W. Main St.

3. NAME OF DECEASED (Type or Print): (First) MYRTLE (Middle) CRAZE (Last) HIGGINS

4. DATE OF DEATH: (Month) Feb. (Day) 19 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 11, 1894

9. AGE last birthday: 54 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: William H. Craze

14. MOTHER'S MAIDEN NAME: Mary Bond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Mary M. Beck

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Ovary (Left) — 6 mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1949, to Feb 19, 1949, that I last saw the deceased alive on Feb 18, 1949, and that death occurred at 8 00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm C Lane MD — ADDRESS: Frostburg Md — DATE SIGNED: Feb 21 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2-22-1949 — NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 2-22-49 — REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR — ADDRESS: J.R. Durst, Frostburg Md.

VS. A15

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FEB 26 1949
BUREAU V. S.

01238

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1
940

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 64 W. College Ave.	STREET ADDRESS (If rural, give location): 64 W. College Ave.

3. NAME OF DECEASED (Type or Print)	(First) HARRY	(Middle) C.	(Last) HITCHINS	4. DATE OF DEATH	(Month) Feb. (Day) 23, (Year) 1949
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: Aug. 6 '69	9. AGE last birthday: 79 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): court crier	10b. KIND OF BUSINESS OR INDUSTRY: Court House	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: John Hitchins	14. MOTHER'S MAIDEN NAME: Sallie Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Grant Hitchins			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thromboses	Sudden
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ——, 1948, to Feb. 23, 1948, that I last saw the deceased alive on Feb 14, 1949, and that death occurred at 730 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. McLane MD		Frostburg Md	2-25-49

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: Feb. 26 '49	NAME OF CEMETERY OR CREMATORY: Allegany Cemetery	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: 2-26-49	REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe	24. FUNERAL DIRECTOR: J. R. Durst,	ADDRESS: Frostburg, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 28 1949
BUREAU V. S.

RECEIVED
FEB 28 1949
BUREAU V. S.

Within corporate limits

01239

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

420.1
94a

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 807 Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 807 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) (Last) Holtzman

4. DATE OF DEATH: (Month) Feb. (Day) 28 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jan. 21-1878

9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chester Co. Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Williams

14. MOTHER'S MAIDEN NAME: Elizabeth Mc Clure

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Daughter) Mrs. J.L. Sellman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I ~~attended~~ saw the deceased from Feb. 28, 1949 to ---------, 19--, that I last saw the deceased alive on 2-28, 1949 and that death occurred at about 9 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming MD		Cumberland Md.	Feb. 28-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	March 2 1949	Rose Hill Cemetery	Cumberland,	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 2, 1949	Winter L. Lantz, M.D. Deputy Medical Examiner L. Allegany Co.	William H. Kight	Cumberland, Md.

RECEIVED
MAR 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

EVIDENCE FOR ADDITION # 18 (c) IS ON:

FILM No. G 119 MAR 28 1949

CERTIFICATE OF DEATH

199.1 01240

53 Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 2 1/2 months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 68 Linden St.	STREET ADDRESS (If rural give location) 224 Gleason St.

3. NAME OF DECEASED (Type or Print)	(First) Emily	(Middle) Mina	(Last) Hout	4. DATE OF DEATH	(Month) February (Day) 23 (Year) 1949
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 8, 1872	9. AGE last birthday 76 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cumberland, Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Handel	14. MOTHER'S MAIDEN NAME Christina Barnhart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. —	17. INFORMANT Jacob Hout			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Insufficiency — 4 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Carcinomatosis — 3 yrs.

(c) Location: face (3/28/49 abs)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) No	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1949, to Feb 23, 1949, that I last saw the deceased alive on Feb 19, 1949, and that death occurred at 4:00 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. E. Hatten	M.D.	167 E. Main St Frostburg Md.	2/25/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/25/49	Greenmount Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-25-49	Mrs. Nancy H. Roe	John J. Hofer, Cumberland, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 26 1949
BUREAU U. S.

01241

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

334

CERTIFICATE OF DEATH

97

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke — LENGTH OF STAY (in this place) 38	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pratt Street Extended	STREET ADDRESS (If rural, give location) Pratt Street Extended

3. NAME OF DECEASED (Type or Print)	(First) Margaret	(Middle) Ellen	(Last) Hutchinson	4. DATE OF DEATH	(Month) Feb.	(Day) 16	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Apr. 27, 1873	9. AGE last birthday 75 yrs.	If under 1 year Months. 8	Days 9	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Peirre, Washington Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Conrad Clay			14. MOTHER'S MAIDEN NAME Ellen Murphy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XXX	(If year, give war or dates of service) XXX	16. SOCIAL SECURITY NO. X XX	17. INFORMANT				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) ~~[illegible]~~ JHW Jr Cerebral arteriosclerosis	2 yrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) ~~Cerebral arteriosclerosis~~ JHW Jr Generalized arteriosclerosis	20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1948, to Feb 16, 1949, that I last saw the deceased alive on Feb 15, 1949, and that death occurred at 7:9 a.m., from the causes and on the date stated above.

SIGNATURE James H Wolverton Jr (Degree or title) M.D. ADDRESS Piedmont W. Va DATE SIGNED Feb 17, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 19, 1949	NAME OF CEMETERY OR CREMATORY St. Peter's	LOCATION (City, town, or county) (State) Westernport, Md.
DATE REC'D BY LOCAL REG. Feb. 18, 1949	REGISTRAR'S SIGNATURE [illegible] Mc	24. FUNERAL DIRECTOR E.S. Boal - Westernport, Md	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

491 01242

107

CERTIFICATE OF DEATH

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Little Orleans — LENGTH OF STAY (In this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Little Orleans
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Little Orleans R. D.	STREET ADDRESS (If rural, give location): Near Little Orleans

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nettie		Kasecamp	Feb. 2, 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	Feb. 9, 1863	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Little Orleans, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jonathan Stott	Mary Albright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	None	Mrs. John Galliher Rawlings, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchial pneumonia	14 days.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) —	
	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-20, 1949, to 2-2, 1949, that I last saw the deceased alive on 1-30-, 1949, and that death occurred at 1 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. J. Armstrong	M. D.	Paw Paw, W. Va.	2-4-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 5, 1949	St. Patricks	Little Orleans, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4, 1949	Carrie A. Brantley	H. Wayne George	Cumberland, Md.

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FEB 10 1949
BUREAU V. S.

Within corporate limits

District 4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 (1243

CERTIFICATE OF DEATH

93d Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): 2 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 221 Baltimore St.	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural, give location): 221 Baltimore St.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Mrs Maria	Loretta	Kenney	Feb	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	white	Widowed	Apr 21, 1865	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Sandy Hook - Md	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Phelan	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Mr Fred Hollen

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis	2 yrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 7, 1947 to Feb 7, 1949 that I last saw the deceased alive on Feb 8, 1949 and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clark S. Jarrett	M.D.	Cumberland	2/9/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 11 1949	St Marys Catholic Cemetery	Petersville	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 9, 1949	Wenter L. Frantz, M.D.	John J Hafer	Cumberland, Md.

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DR. DURRETT

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

776 01244
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CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY: ALLEGANY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND LENGTH OF STAY (in this place): 5 MIN. HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: MARYLAND COUNTY: ALLEGANY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND. STREET ADDRESS (If rural, give location): 313 Caroline Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
~~BABY~~ SUSAN	~~GIRL~~ LEE	KERNS	February	3	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE		FEB. 3, 1949	yrs.				5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Cumberland, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
MR. ALBERT KERNS, JR.	RUBY S. SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Premature (24 wks)	5 min.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED White at Work ☐ Not White At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on Feb. 3, 1949, and that death occurred at 4:47 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Capt. Lewis	M.D.	Cumberland, Md.	

23. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	Feb. 4, 1949	Memorial Hosp.	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4, 1949	Winter R. Frantz, M.D.	Memorial Hosp.,	Cumberland, Md.

VS. A15

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BUREAU V. S.

Within corporate limits

DR. ROBINSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

157 2nd

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH COUNTY: ALLEGANY — STATE: MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD. — LENGTH OF STAY (in this place): HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Cumberland — COUNTY: Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland Rural STREET ADDRESS (If rural give location): Narrows Park R.F.D. #6
3. NAME OF DECEASED (Type or Print): (First) SANDRA (Middle) KAY (Last) Knippenberg	4. DATE OF DEATH: (Month) FEB. (Day) 19 (Year) 49
5. SEX: FEMALE — 6. COLOR OR RACE: WHITE — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE — 8. DATE OF BIRTH: 8-18-48 — 9. AGE last birthday: yrs. — If under 1 year: Months 6 MO. Days — If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C. — 12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: UNKNOWN — 14. MOTHER'S MAIDEN NAME: [redacted] Esther Knippenberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT: Memorial Hospital	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Diarrhea, Dehydration, acidosis	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ~~Congenital Heart~~	Life
(c) Pneumonia	4 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congenital Heart, Pneumonia	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/14, 19 49, to 2/19, 19 49, that I last saw the deceased alive on 2/19, 19 49, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Thomas Robinson	M.D.	195 Liberty St. Cumberland, Md.	2/19/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 21, 1949	Zion Memorial Park	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 21, 1949	Winter R. Bantz, M.D.	John J. Hafer,	Cumberland, Md.

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Within corporate limits DR. W. F. WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 116 OAK STREET

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) W. (Last) KOSER

4. DATE OF DEATH: (Month) FEB. (Day) 3 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: AUG. 26, 1891

9. AGE last birthday: 57 yrs. If under 1 year: Months 5, Days 7; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST

10b. KIND OF BUSINESS OR INDUSTRY: B & O R. R.

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN KOSER

14. MOTHER'S MAIDEN NAME: MARGARET JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 705- 05- 5268

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocardial Degeneration

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arteriosclerosis

(c) Hypertension.

INTERVAL BETWEEN ONSET AND DEATH: 3.4.43

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3.4., 1943, to 2.3., 1949, that I last saw the deceased alive on 6.6., 1946, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. F. Williams ADDRESS: Cumberland DATE SIGNED: 2/5/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Feb. 6, 1949
NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 5, 1949
REGISTRAR'S SIGNATURE: Winter R. Mantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (In this place) Life Time
HOSPITAL OR INSTITUTION OR STREET ADDRESS 814 Washington St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 81 Washington St.

3. NAME OF DECEASED (Type or Print) (First) Maud (Middle) Rosella (Last) Kroll

4. DATE OF DEATH (Month) (Day) (Year) 2 - 22 - 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Jan. 31-1881
9. AGE last birthday 68 yrs. If under 1 year: Months 0, Days 21; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Borden Shaft
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME John Ort
14. MOTHER'S MAIDEN NAME Ellen Whitehead

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr John Kroll

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cirrhosis of Liver

(c)

INTERVAL BETWEEN ONSET AND DEATH: 3 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1, 1949, to 2/22, 1949, that I last saw the deceased alive on 1/22, 1949, and that death occurred at 8:40 A m., from the causes and on the date stated above.

SIGNATURE R W Reeves M D (Degree or title) ADDRESS Westernport Md DATE SIGNED 2/24/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-25-1949
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) (State) Frostburg, Alleg. Md.

DATE REC'D BY LOCAL REG. 2-25-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer
ADDRESS Frostburg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

055 10

01248

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital; MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 707 Maryland ave.

3. NAME OF DECEASED (Type or Print): (First) Rosemary (Middle) (Last) Lydinger (1st Twin)

4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Nov. 5 1943

9. AGE last birthday: 5 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Valentine Lydinger

14. MOTHER'S MAIDEN NAME: Bertha Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Valentine Lydinger

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Laryngeal Diphtheria — Interval Between Onset and Death: 2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐:

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb-3, 1949 to Feb 4, 1949, that I last saw the deceased alive on Feb. 4, 1949, and that death occurred at 10:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clay F. Lumm M.D. Cumberland 2/5/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2-6-49 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cem. — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 6, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR ADDRESS: Charles L. George - Cumberland, Md.

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

002 01249

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (In this place) 2 Cyrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS College Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 138 College Ave.

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) Findley (Last) McKee

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 26-85

9. AGE last birthday: 64 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Findley

14. MOTHER'S MAIDEN NAME: Martha White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: George McKee

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) pulmonary tuberculosis and diabetes.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-19, 1948, to 7-20, 1948, that I last saw the deceased alive on 7-20, 1948, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE: L. Wolferman (Degree or title): M.D ADDRESS: Frostburg DATE SIGNED: 2-18-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: Feb. 19, '49 NAME OF CEMETERY OR CREMATORY: Allegany Cemetery LOCATION (City, town, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG. 2-18-49 REGISTRAR'S SIGNATURE: Mrs. Nancy K Poe

24. FUNERAL DIRECTOR: M. Eichhorn ADDRESS: Lonaconing Md

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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51 b

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Rural~~-Frostburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS ~~Rural-Frostburg~~ Miners Hosp.	STREET ADDRESS (If rural, give location) Long Stretch, Route 40

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARSHALL THOMAS McMAHON	4. DATE OF DEATH (Month) (Day) (Year) Feb. 21 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
Male	White	Single	Sept. 12 '91	57 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Invalid		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hugh McMahon	Lydia Carey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		none	Carey McMahon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pneumonia - left lung, both lobes	48 hrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinomatosis - prostate, intestines	1 YR. or more
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	✓	Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 20, 1949, to Feb. 21, 1949, that I last saw the deceased alive on Feb. 21, 1949, and that death occurred at 10:50 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin M. Rothstein M.D.		48 Broadway Frostburg, Md.	2/23/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 24 '49	St. Michael's Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-23-49	Mrs. Hauley H. Roe	J. R. Durst	Frostburg Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
FEB 26 1949
BUREAU T. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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01251

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
STREET ADDRESS (If rural, give location) 328 Cumberland St.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Andrew (Last) Malloy
4. DATE OF DEATH (Month) Feb. (Day) 18 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH July 23 1882
9. AGE last birthday 66 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail Way Mail Clerk
10b. KIND OF BUSINESS OR INDUSTRY U.S. Mail
11. BIRTHPLACE (State or foreign country) Cambridge Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Patrick Malloy
14. MOTHER'S MAIDEN NAME Mary Ann Flynn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs Margaret O'Rowke Malloy.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of colon

Antecedent cause(s) (b) Intestinal obstruction

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH —

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION 2/11/49
19b. MAJOR FINDINGS OF OPERATION Carcinoma of colon.
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/7, 1949, to 2/18, 1949, that I last saw the deceased alive on 2/18, 1949, and that death occurred at 9:40 AM m., from the causes and on the date stated above.

SIGNATURE John H. Rozum M.D. (Degree or title) ADDRESS Cumberland Md DATE SIGNED 2/19/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 21/49
NAME OF CEMETERY OR CREMATORY St. Patricks Cem.
LOCATION (City, town, or county) Cumberland (State) Md.
DATE REC'D BY LOCAL REG. Feb. 20, 1949
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

RECEIVED
MAR 2 1949
BUREAU V. S.

Within corporate limits

01252

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 157 Polk St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 157 Polk St.

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Louis (Last) Metty

4. DATE OF DEATH (Month) Feb. (Day) 6 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH March 17 1865
9. AGE last birthday 83 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired shoemaker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Topeka Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gilbert Metty
14. MOTHER'S MAIDEN NAME Ella Laird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT daughter) Mrs. Jos. Hoban

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of the stomach — about 1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Feb. 6, 1949, to ~~19~~, that I last saw the deceased ~~alive~~ Dead on Feb. 6, 1949, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE H.V. Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Feb. 7-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb. 9 1949
NAME OF CEMETERY OR CREMATORY Hillcrest Cem
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Feb. 9, 1949
REGISTRAR'S SIGNATURE Winter R. Krantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

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FEB 15 1949
BUREAU V. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 22 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 809 Kentucky Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 809 Kentucky Ave.

3. NAME OF DECEASED (Type or Print): (First) Rosa (Middle) Lee (Last) Morris

4. DATE OF DEATH: (Month) Feb (Day) 22 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 10/28/79

9. AGE last birthday: 69 yrs.
If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Grafton W. Va

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James Knotts

14. MOTHER'S MAIDEN NAME: Matilda McDaniel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Stanley C. Morris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	1 week
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Congestive heart disease (arteriosclerotic + hypertensive)	2 yr.
	(c) Diabetes	10 yr. (?)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | **PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)** | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 5, 1949, to Feb 22, 1949, that I last saw the deceased alive on Feb 21, 1949, and that death occurred at 6:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Estelle G. Weisman	M.D.	Cumberland, Md	4/23/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/24/49	Parsons Cemetery	Parsons W. Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 24, 1949	Wexter L. Mantz, M.D.	John J. Hafer	Cumberland, Md.

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MAR 2 1949
BUREAU V. S.

Within corporate limits DR. FAW

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

171

CERTIFICATE OF DEATH

480

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 77 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location) 212 SEYMOUR STREET

3. NAME OF DECEASED (Type or Print)	(First) ELIZABETH	(Middle) DOROTHY	(Last) MURRAY	4. DATE OF DEATH	(Month) FEB.	(Day) 22	(Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JUNE 22, 1895	9. AGE last birthday 53 yrs.	If under 1 year Months 8	Days 0	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY House	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME JOSEPH GLESSNER	14. MOTHER'S MAIDEN NAME MAGGIE SELL						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Squamous cell carcinoma cervix

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) uteri with extension and general cachexia

(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Nov. 1948

19b. MAJOR FINDINGS OF OPERATION Transplantation ureters General extension squamous carcinoma cervix

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Feb 22, 1949, that I last saw the deceased alive on Feb 22, 1949, and that death occurred at 12 29 A.m., from the causes and on the date stated above.

SIGNATURE: Wylie M Faw Jr (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED Feb 23, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 25 1949	Woodlawn Cemetery	Baltimore	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 24, 1949	Winter R. Frantz, M.D.	William H. Kight	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 2 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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331
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CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 609 Piedmont Ave.	STREET ADDRESS (If rural, give location): 609 Piedmont Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Katherine	Nave	Feb.	18	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	white	married	Aug. 14-1888	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Cumberland Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Cope	Katherine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		----	Claude F. Nave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage (Apoplexy)	about 1/2 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis & hypertension	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. myocarditis — about 2 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I saw the deceased from Feb. 18, 1949, to ----------, 19---, that I last saw the deceased Dead alive on Feb. 18, 1949, and that death occurred at about 3 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H. V. Deming M.D. H. V. Deming M.D.	Cumberland Md.	Feb. 18- 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/20/49	Rose Hill	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 20, 1949	Winter R. Frantz M.D. Deputy Medical Examiner - Allegany Co.	Charles L. George	Cumberland, Md.

VS. A15

RECEIVED
MAR 2 1949
BUREAU V. S.

Within corporate limits DR. REES

MARYLAND STATE DEPARTMENT OF HEALTH

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2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (In this place) 4 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL Hospital	STREET ADDRESS (If rural give location) 508 HILL STREET

3. NAME OF DECEASED (Typo or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ROBERT	Frank	NELSON		FEB.	28,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
MALE	WHITE	WIDOWER	JUNE 11, 1879	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer - Retired	Celanese Corp	MARYLAND	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
MARTIN NELSON	VIRGINIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	214-07-1857	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	6 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	Indefinite
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 2-22, 1949, to 2-28, 1949, that I last saw the deceased alive on 2-28, 1949, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE Robert T. Rees M.D. (Degree or title) ADDRESS 620 McCulloch St DATE SIGNED 3/1/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	March 4 1949	Greenmount Cemetery	Cumberland	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 3, 1949	Wintes K. Lantz, M.D.	William H. Kight	Cumberland, Md.

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MAR 7 1949
BUREAU V. S.

Within corporate limits

DR. WILSON

01257

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

902.8
186a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. — LENGTH OF STAY (in this place) 5 HOURS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LONACONING
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 122 JACKSON STREET

3. NAME OF DECEASED (Type or Print)	(First) MARGARET	(Middle) LEE	(Last) NICOL	4. DATE OF DEATH	(Month) FEBRUARY (Day) 3, (Year) 1949
5. SEX female	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH NOV. 18, 1936	9. AGE last birthday 12 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LEE L. NICOL		14. MOTHER'S MAIDEN NAME MARY FOLTZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial hemorrhage — about 7

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Basil fracture of the skull — hours

(c) Sled riding, missed bridge & fell about 8 Ft.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. into Jackson's Creek.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jackson's Creek	(CITY OR TOWN) Lonaconing	(COUNTY) Allegany	(STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Feb. 2-1949-8 P m.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR? 8 Ft. into jackson's Creek Sled riding, missed bridge & fell about		

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Feb. 3, 1949, to -------, ~~19--~~, that I last saw the deceased Dead alive on Feb. 3, 1949, and that death occurred at 2.15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H. V. Deming M.D.	Cumberland Md.	3-3-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb 5 1949	NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	LOCATION (City, town, or county) (State) Lonaconing, Md.
DATE REC'D BY LOCAL REG. Feb. 5, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz M.D.	24. FUNERAL DIRECTOR M. Eichhorn	ADDRESS Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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93d

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing — LENGTH OF STAY (in this place): 38 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
HOSPITAL OR INSTITUTION OR STREET ADDRESS: St. Mary's Terrace	STREET ADDRESS (If rural, give location): St. Mary's Terrace

3. NAME OF DECEASED (Type or Print)	(First) Daniel	(Middle) A.	(Last) Nolan	4. DATE OF DEATH	(Month) Feb	(Day) 14	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Feb. 15, 1881	9. AGE last birthday: 67 yrs.	If under 1 year: Months.	Days	If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal mining	10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining	11. BIRTHPLACE (State or foreign country): Unknown	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Daniel Nolan		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: 214-05-9718	17. INFORMANT: John Nolan	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Ischemia & Cardiac Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c) Hypertensive Cardio-Vascular disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul Eugene Frye	M.D.	Lonaconing	Md 2/15/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Feb. 16, 49	NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery	LOCATION (City, town, or county): Lonaconing	(State): Md
DATE REC'D BY LOCAL REG.: 2/16/49	REGISTRAR'S SIGNATURE: Jannette McCool	24. FUNERAL DIRECTOR: M. Eichhorn	ADDRESS: Lonaconing Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany Mt Savage MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mount Savage
LENGTH OF STAY (in this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Foundry Row, Mt Savage, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mount Savage Md.
STREET ADDRESS (If rural, give location) Foundry Row

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) JANE (Last) WITT
4. DATE OF DEATH (Month) (Day) (Year) February 2 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH Sept. 20, 1867
9. AGE last birthday 81 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rowelsburg, West. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Shaffer
14. MOTHER'S MAIDEN NAME Catherine Nestor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Edith Minnick (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	36 hrs.
Antecedent cause(s)	(b) Arteriosclerotic Heart disease, General-	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) ized Arteriosclerosis - Senile Psychosis -	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bilateral optic atrophy

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 6, 1949, to Feb. 2, 1949, that I last saw the deceased alive on February 2, 1949, and that death occurred at 6.15 P m., from the causes and on the date stated above.

SIGNATURE James P. Hallinan (Degree or title) M.D. ADDRESS Mt. Savage, Maryland DATE SIGNED Feb. 2, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 2-6-49 NAME OF CEMETERY OR ~~CREMATORY~~ Methodist LOCATION (City, town, or county) (State) Mt Savage-Alleg-Md

DATE REC'D BY LOCAL REG. Feb. 6 - 1949 REGISTRAR'S SIGNATURE Vennera McDermott
24. FUNERAL DIRECTOR Joseph R. Durst ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg | LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural give location): Grahamtown

3. NAME OF DECEASED (Type or Print): (First) Hannah (Middle) Yates (Last) Offman
4. DATE OF DEATH: (Month) Feb (Day) 23 (Year) 1949

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: May 28, 1865 | 9. AGE last birthday: 83 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework | 10b. KIND OF BUSINESS OR INDUSTRY: Own home | 11. BIRTHPLACE (State or foreign country): Frostburg, Md | 12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph Yates | 14. MOTHER'S MAIDEN NAME: Mary Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service): no | 16. SOCIAL SECURITY NO.: none | 17. INFORMANT: Mrs Nellie Offman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Congestive Nephritis — 4 Days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fracture Rt Femur — 16 days

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home | (CITY OR TOWN): Frostburg | (COUNTY): Allegany | (STATE): Md

TIME OF INJURY (Month) Feb (Day) 8 (Year) 1949 (Hour) 1:30 p.m. | INJURY OCCURRED While at Work ☐ Not While At work ☒ | HOW DID INJURY OCCUR: Fell on steps outside kitchen door

22. I hereby certify that I attended the deceased from Feb 8, 1949, to Feb 23, 1949, that I last saw the deceased alive on Feb 23, 1949, and that death occurred at 2:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
W. M. McLane M.D | Frostburg Md | Feb 23 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Buried | DATE THEREOF: Feb 27 1949 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md

DATE REC'D BY LOCAL REG.: 2-26-49 | REGISTRAR'S SIGNATURE: Mrs. Nancy V. Roe | 24. FUNERAL DIRECTOR | ADDRESS: M. Eichhorn Company Md

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FEB 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 161 Green St.

3. NAME OF DECEASED (Type or Print) (First) Jean (Middle) Walker (Last) Ort

4. DATE OF DEATH (Month) 2 (Day) 17 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 12-11-1873
9. AGE last birthday 75 yrs. If under 1 year Months 2 Days 6 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Westernport, Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George Chapman
14. MOTHER'S MAIDEN NAME Jean Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Katherine Yates

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	6 Days
Antecedent cause(s)	(b) Cerebral Embolism	5 Days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 11, 1949, to Feb 17, 1949, that I last saw the deceased alive on Feb 17, 1949, and that death occurred at 11 00 P m., from the causes and on the date stated above.

SIGNATURE W. D. McLane (Degree or title) MD ADDRESS Frostburg Md DATE SIGNED Feb 18 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-20-1949
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 2-19-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hofer ADDRESS Frostburg Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

445
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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE 205 Penna. Ave. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 29 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 205 Penna. Ave	STREET ADDRESS (If rural, give location) 205 Penna. Ave.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Charleen C. Painter	4. DATE OF DEATH (Month) (Day) (Year) 2 7 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
F	W	Married	Nov. 17, 1919	29 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Charles C. Bowden		14. MOTHER'S MAIDEN NAME Elizeabith Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Robt. Painter	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Malignant Hypertension — 8 mos

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1948, to Feb. 7, 1949, that I last saw the deceased alive on Feb. 6, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clay E. Furrett - M.D. - Cumberland - Feb. 8. 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 9, 1949	Hillcrest Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 8, 1949	Winter R. Frantz, M.D.	James F. Scarpelli	Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 15 1949
BUREAU T. S.

Within corporate limits

Simon

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 16 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 110 Springdale St.

3. NAME OF DECEASED (Type or Print) (First) Andrew (Middle) Jacob (Last) Parker

4. DATE OF DEATH (Month) Feb (Day) 15 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec 2 1889
9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor
10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad
11. BIRTHPLACE (State or foreign country) Romney W. Va
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Samuel Parker
14. MOTHER'S MAIDEN NAME Mary Biser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W War I
16. SOCIAL SECURITY NO. 705-10-1587
17. INFORMANT Isaac Parker.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebro vascular Accident	8 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	Unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/7, 1949, to 2/15, 1949, that I last saw the deceased alive on 2/15, 1949, and that death occurred at 7:45 A.m., from the causes and on the date stated above.

SIGNATURE George M Simons (Degree or title) M.D. ADDRESS 128 Union St. Cumberland Md. DATE SIGNED 2/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Feb 17, 1949
NAME OF CEMETERY OR CREMATORY Indian Mound Cem.
LOCATION (City, town, or county) Romney (State) W. Va.

DATE REC'D BY LOCAL REG. Feb. 17, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

01263

2411 N. Charles Street, Baltimore

4201
932

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 314 Baltimore Ave.	STREET ADDRESS (If rural, give location) 314 Baltimore Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	W.	Rausch	Feb.	16	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
male	white	single	Nov. 24-1902	46 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Music teacher	Teaching music	Cumberland Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James M. ~~Rousch~~ Rausch	Mattie De Vore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no –	----	Mrs. Mattie Rousch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(e) Coronary occlusion	at once
Antecedent cause(s)	Coronary sclerosis	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocardial degeneration.	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, ferm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I ~~attended~~ saw the deceased from 2-17, 1949, to 1:05 A.M., 19--, that I last saw the deceased ~~alive~~ Dead on 2-17, 1949, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.		Cumberland Md.	2-16-49 Feb. 17-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	February 19, 1949	Hyndman Cemetery	Hyndman, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 19, 1949	Winter R. Bantz M.D. Deputy Medical Examiner - Allegany Co.	John J. Hofer,	Cumberland, Md.

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. S.

Within corporate limits

M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2

93e

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 25 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 213 Glenn St.

3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) Sheridan	(Last) Reed	4. DATE OF DEATH	(Month) Feb (Day) 1 (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Oct 5, 1869	9. AGE last birthday: 79 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman	10b. KIND OF BUSINESS OR INDUSTRY: Soft Drinks	11. BIRTHPLACE (State or foreign country): New York State	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: James Reed	14. MOTHER'S MAIDEN NAME: Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Robt R. Reed			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis — Two Months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 1, 1949, to Feb 1, 1949, that I last saw the deceased alive on Feb. 1, 1949, and that death occurred at Cumberland Md, from the causes and on the date stated above.

SIGNATURE: J. Johnson Jr. (Degree or title) M.D. — ADDRESS: Cumberland Md — DATE SIGNED: 2-4-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Feb 4, 1949	NAME OF CEMETERY OR CREMATORY: Pleasant Grove	LOCATION (City, town, or county) (State): Rt. 40 East of Cumberland, Md.
DATE REC'D BY LOCAL REG.: Feb. 4, 1949	REGISTRAR'S SIGNATURE: Winter R. Lantz M.D.	24. FUNERAL DIRECTOR: John J. Hofer	ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. S.

01265

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

322.1 77d

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): 1 day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) COBEY	(Last) REPHANN	4. DATE OF DEATH	(Month) Feb. (Day) 27, (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Marries	8. DATE OF BIRTH: 2-28-12	9. AGE last birthday: 36 yrs.	If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner	10b. KIND OF BUSINESS OR INDUSTRY: Coal mines	11. BIRTHPLACE (State or foreign country): Eckhart, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Conrad Rephann	14. MOTHER'S MAIDEN NAME: Catherine Lancaster				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT: Mrs. James C. Rephann			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral oedema (acute)	10 hours.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic alcoholism	20 years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-26, 1949, to 2-27, 1949, that I last saw the deceased alive on 2-27, 1949, and that death occurred at 6:15 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. C. Diehl, M.D.		Frostburg, Md.	3/2/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Mar. 2 '49	NAME OF CEMETERY OR CREMATORY: Porter Cemetery	LOCATION (City, town, or county) (State): Eckhart, Md.
DATE REC'D BY LOCAL REG.: 3-2-49	REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR: J. R. Durst	ADDRESS: Frostburg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 5 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01266

422.1
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): ; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 146 Wineow St.	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural, give location): 146 Wineow St.

3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) Henry	(Last) Rhodes	4. DATE OF DEATH	(Month) Feb.	(Day) 2	(Year) 1949	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
male	colored	Widower	Oct. 12-1869	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer		Cumberland Md.	U.S.A.

13. FATHER'S NAME: Thomas Parker	14. MOTHER'S MAIDEN NAME: Mary Jane Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Mary Jane Rhodes

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis	about 1 year
Antecedent cause(s)	Arteriosclerosis	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I ~~attended~~ saw the deceased from Feb. 2, 1949, to ~~1949~~, that I last saw the deceased ~~alive~~ Dead on Feb. 2, 1949 and that death occurred at 10.30 Am., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H. V. Deming M.D.		Cumberland Md.	Feb. 2-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/7/49	St. Peter & Paul's Cem.	Cumberland,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 5, 1949	Wintes K. Faulk M.D.	John J. Hafer.	Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

RECEIVED
FEB 10 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

334
832

01267

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Rural (Cumberland)
LENGTH OF STAY (In this place): 78 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 1, Homewood Addition

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (Rural) Cumberland
STREET ADDRESS (If rural give location): Route 1, Homewood Addition

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ranson	Howard	Rice	February	16	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	April 2 1870	78 yrs.	10	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shopman, Colored	Western Md R.R.	Cumberland, Md	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lloyd Rice	Ruth Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Mrs. Emma Rice

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hemiplegia	3 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None	Home	Cumberland	Alleg.	Md.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
— m.		—

22. I hereby certify that I attended the deceased from Jan. 28, 1949, to Feb. 11, 1949, that I last saw the deceased alive on Feb. 11, 1949, and that death occurred at 6:45 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Blanche Schindler	M. D.	41 Greene St. Cumberland Md.	2/17/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 19, 1949	Mt. Pleasant Cemetery	Cumberland	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 18, 1949	Winter L. Frantz, M.D.	William H. Kight	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

154 462 01268

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place) 3 8 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS St Mary's Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) St Marys Terrace

3. NAME OF DECEASED (Type or Print): (First) Edward (Middle) Geo. (Last) Robertson

4. DATE OF DEATH: (Month) February (Day) 8 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Dec 6, 1883

9. AGE last birthday: 65 yrs. If under 1 year: Months. 2 Days 12 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Lonaconing Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Andrew Robertson

14. MOTHER'S MAIDEN NAME: Mary Gedige

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 182-01-3561

17. INFORMANT: Mrs. Edward Harvey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Malignancy of rectum - generalized metastases — Interval Between Onset and Death: 4 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): None m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947 19..., to 2/8, 1949, that I last saw the deceased alive on 2/8, 1949, and that death occurred at 12:15 p m., from the causes and on the date stated above.

SIGNATURE: Paul Eugene Frye (Degree or title) M.D. ADDRESS Lonaconing Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Feb 11, 1949 — NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery — LOCATION (City, town, or county) (State): Lonaconing Allegany Co Md

DATE REC'D BY LOCAL REG.: Feb 11 1949 — REGISTRAR'S SIGNATURE: Jeanette McCool

24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing Md.

RECEIVED
FEB 28 1940
BUREAU V. S.

Within corporate limits

DR. DURRETT

01269

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

761.5

CERTIFICATE OF DEATH

160.C Reg. Dist. No. 4

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

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VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 322 GRAND AVE

3. NAME OF DECEASED (Type or Print) (First) ~~[illegible]~~ ORIE LEO (Middle) ~~[illegible]~~ (Last) Royce

4. DATE OF DEATH (Month) FEB. (Day) 24 (Year) 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH FEB 23, 1949

9. AGE last birthday yrs. If under 1 year Months Days 1 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME ORIE L ROYCE

14. MOTHER'S MAIDEN NAME DOROTHY WINEBRENNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ——

17. INFORMANT Orie L. Royce

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Premature 30 wks.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ruptured Placenta

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1949, to Feb. 24, 1949, that I last saw the deceased alive on Feb. 24, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Clay J. Durrett (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED Feb. 24/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Feb. 25, 1949

NAME OF CEMETERY OR CREMATORY Zion Memorial Park

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Feb. 25, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR John J. Hofer ADDRESS Cumberland, Md.

RECEIVED
MAR 2 1949
BUREAU V. S.

Within corporate limits

Dr. Louis Briggs

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

480

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) Lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 539 Patterson Ave	STREET ADDRESS (If rural give location) 539 Patterson Avenue

3. NAME OF DECEASED (Type or Print)	(First) Virginia	(Middle) Elizabeth	(Last) Shaffer	4. DATE OF DEATH	(Month) Feb	(Day) 18	(Year) 1949
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 3, 1890	9. AGE last birthday 58 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Allegany Co. Md	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William H. Duckworth	14. MOTHER'S MAIDEN NAME Julia Doman						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. —	17. INFORMANT Mrs. Harold Shaner					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cancer of the cervix	2 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION 6-2-48	19b. MAJOR FINDINGS OF OPERATION Cancer of the cervix	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1-, 1948, to 2-18-, 1949, that I last saw the deceased alive on 2-18-, 1949, and that death occurred at 1030 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L. Briggs		59 Greene St. Cumberland	Mar 21-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb 21, 1949	NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	LOCATION (City, town, or county) (State) Cumberland, Md
DATE REC'D BY LOCAL REG. Feb. 21, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hofer	ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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2411 N. Charles Street, Baltimore

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EVIDENCE FOR ADDITIONAL INFO. # 18b. IS ON: FICHE # G 119 - 4-1-49 A

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The effect of is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 4 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 419 Vine Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural give location) 419 Vine Street

3. NAME OF DECEASED (Type or Print): (First) Eugene (Middle) Clark (Last) Shahan

4. DATE OF DEATH: (Month) Feb. (Day) 18 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 28, 1870

9. AGE last birthday: 78 yrs. If under 1 year: Months 8 Days 20 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Saw-Mill

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Allan Shahan

14. MOTHER'S MAIDEN NAME: Mary E. Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---; (If yes, give war or dates of service) ---

16. SOCIAL SECURITY No. 232-26-3840

17. INFORMANT: Victoria Shahan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151 Immediate cause (a) Carcinomatosis — Interval between onset and death: 6 mo

46b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer of Stomach (3/20/49-So.) — Cancer

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Embolism of Lower Extremity — Surg

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/17, 19..., to 2/18, 19..., that I last saw the deceased alive on 2/17, 1949, and that death occurred at 6:9 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED 2/19/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 20, 1949 — NAME OF CEMETERY OR CREMATORY: Mt. Isreal — LOCATION (City, town, or county) (State): Fellowsville, W. Va.

DATE REC'D BY LOCAL REG. 2-20-49 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR: C. C. Beal — ADDRESS: Westernport, Md.

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DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 32 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MD.
COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: DEER PARK
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) SHARPLESS (Last)

4. DATE OF DEATH: (Month) FEB. (Day) 8 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: DEC. 25, 187[illegible]

9. AGE last birthday: 70 yrs. If under 1 year: Months 11, Days 5, If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANCES SHARPLESS

14. MOTHER'S MAIDEN NAME: ELIZABETH FULMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	3 mos
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	3 yrs
	(c) Gangrene Toes Left Foot	6 wks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Jan. 15, 1949

19b. MAJOR FINDINGS OF OPERATION: Gangrene Toes Left Foot

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 10, 1949, to Feb 8, 1949, that I last saw the deceased alive on Feb 8, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE: Clay E. Durrett (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: Feb 9/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Feb 11 1949
NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetery
LOCATION (City, town, or county) (State): Kitzmiller, Maryland

DATE REC'D BY LOCAL REG.: Feb. 9, 1949
REGISTRAR'S SIGNATURE: Walter L. Fauntz, M.D.
24. FUNERAL DIRECTOR: Otha F. Sharpless, ADDRESS: Blaine, W. Va.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place) 24 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Vance (Last) Sharpless

4. DATE OF DEATH: (Month) Feb. (Day) 11, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Oct. 25, 1874

9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Mineral Co., W.Va.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Benjamin Sharpless

14. MOTHER'S MAIDEN NAME: Amy Paugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: 232-09-8956

17. INFORMANT: Otha F. Sharpless- Blaine, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cancer of digestive organs and Peritoneum — Liver and Biliary passages — Interval Between Onset and Death: 4 Months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Secondary Anemia and Cardiac Insufficiency — 2 Months

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Nov. 16, 1948, to Feb 11, 1949, that I last saw the deceased alive on Feb. 11, 1949, and that death occurred at 5:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Paul A. Wilson M.D. Piedmont, W. Va. Feb. 12, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Feb. 13 /49
NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cem. Elk Garden
LOCATION (City, town, or county) (State): Mineral Co., W.Va.

DATE REC'D BY LOCAL REG. Feb 18, 1949
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR: W.H. Kight, Cumberland, MD.
ADDRESS

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Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Pennsylvania COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): One Month	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Johnstown
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 508 Shriver Ave	STREET ADDRESS (If rural give location): 526 Vine Street ✓

3. NAME OF DECEASED (Type or Print)	(First) Mayme	(Middle)	(Last) Shuck	4. DATE OF DEATH	(Month) February	(Day) 19	(Year) 1949
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: Nov 6 1876	9. AGE last birthday: 72 yrs.	If under 1 year Months: 3 Days: 13	If under 24 hrs. Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House	10b. KIND OF BUSINESS OR INDUSTRY: House	11. BIRTHPLACE (State or foreign country): Cumberland, Allegany Co, Md	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME: Thomas P. Clark	14. MOTHER'S MAIDEN NAME: Laura Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Miss Mazie Clark					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Failure — Dec 1948

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — ?

(c) Myocardial Disease - Coronary Artery Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 8, 1949 to Feb 19, 1949, that I last saw the deceased alive on Feb 18, 1949, and that death occurred at 10 30 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Samuel V. Jacobson	MD	50 Pershing St.	2/21/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Feb 22 1949	NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: Feb. 22, 1949	REGISTRAR'S SIGNATURE: Walter K. Lantz, M.D.	24. FUNERAL DIRECTOR: William H. Kight,	ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 78 Yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural give location): 227 Bedford Street

3. NAME OF DECEASED (Type or Print)	(First) Minerva	(Middle) Elizabeth	(Last) Shuck	4. DATE OF DEATH	(Month) February (Day) 17 (Year) 1949
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH: July 5 1870	9. AGE last birthday: 78 yrs.	If under 1 year: Months 7, Days 2; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House	10b. KIND OF BUSINESS OR INDUSTRY: House	11. BIRTHPLACE (State or foreign country): Cumberland, Allegany Co, Md.	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: Frank Seiss	14. MOTHER'S MAIDEN NAME: Louisa Dilley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Mrs Elizabeth Shuck			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Nephritis	Unknown
	(c) Arterio Sclerosis	Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/10, 1949 to 2/18, 1949, that I last saw the deceased alive on 2/17, 1949, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) ADDRESS: [illegible] DATE SIGNED: 2/18/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Feb 20, 1949	NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: Feb. 18, 1949	REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.	24. FUNERAL DIRECTOR: William H. Kight	ADDRESS: Cumberland, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 15 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 75 Armstrong St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Grahamtown, Frostburg
STREET ADDRESS (If rural, give location) 75 Armstrong St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Valentine	Shuey	12	28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Feb. 14, 1881	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Products Co.	Lingleston Pa.	U. S.

13. FATHER'S NAME John Shuey — 14. MOTHER'S MAIDEN NAME Louise Sanders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Mrs. W. V. Shuey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma Lungs Dilated

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma transverse colon

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 25 Dec, 1948, to 28 Feb, 1949, that I last saw the deceased alive on 28 Feb, 1949, and that death occurred at 12:00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John B. Davis, MD		Frostburg, Md.	3/1/49.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3-3-1949	Allegany Cemetery	Frostburg, Md.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-1-49	Wm Harvey H. Rae	Jacob Hafer	Frostburg, Md.

RECEIVED
MAR 5 1949
BUREAU V. S.

01277

Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Oldtown — LENGTH OF STAY (In this place) 68 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Oldtown
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 1, Oldtown	STREET ADDRESS (If rural, give location) Rt. 1, Oldtown

3. NAME OF DECEASED (Type or Print)	(First) Rosa	(Middle) Lee	(Last) Slider	4. DATE OF DEATH	(Month) February (Day) 8 (Year) 1949
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH May 16, 1880	9. AGE last birthday 68 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Flintstone, Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael O. Twigg	14. MOTHER'S MAIDEN NAME Amanda J. Kifer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. —	17. INFORMANT Mrs. Velda G. Twigg			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	20 hrs.
Antecedent cause(s)	(b) Cerebral Hemorrhage	1943
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) c̄ R. Hemiplegia	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1943, to Feb. 8, 1949, that I last saw the deceased alive on Feb. 7, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clay G. Furrey	M.D.	Cumberland	2/9/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 10, 1949	NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	LOCATION (City, town, or county) Cumberland, Md (State)
DATE REC'D BY LOCAL REG. Feb. 9, 1949	REGISTRAR'S SIGNATURE Carrie A. Stranholtz	24. FUNERAL DIRECTOR John J. Hofer	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

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RECEIVED
FEB 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

01278

2411 N. Charles Street, Baltimore 334

CERTIFICATE OF DEATH 83a

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 66 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 936 Gay St	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 936 Gay St.
3. NAME OF DECEASED (Type or Print): (First) William (Middle) Floyd (Last) Smith	4. DATE OF DEATH: (Month) Feb. (Day) 24 (Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 17 1882	9. AGE last birthday 66 yrs.	If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Cumb'd Steel Co	11. BIRTHPLACE (State or foreign country) Cumberland Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Martin D. Smith	14. MOTHER'S MAIDEN NAME Mollie Hartley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 214-05-9512	17. INFORMANT Minnie Wigfield Smith (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Vascular Accident	5 Days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	3 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 9, 1948, to Feb. 24, 1949, that I last saw the deceased alive on Feb. 20, 1949, and that death occurred at 6:50 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Feb. 25, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 26 '49	Mt. Herman Cem.	Rural Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 25 1949	Winter K. Frantz, M.D.	Louis Stein Inc	Cumberland

VS. A15

RECEIVED
MAR 2 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01279

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
MARYLAND LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS 28 State St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Md
STREET ADDRESS (If rural, give location) 28 State St.

3. NAME OF DECEASED (Type or Print) (First) Ernest (Middle) George Andrew (Last) Snider

4. DATE OF DEATH (Month) Feb (Day) 6 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH Nov 11, 1897

9. AGE last birthday 51 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Painter

10b. KIND OF BUSINESS OR INDUSTRY Self Employed

11. BIRTHPLACE (State or foreign country) Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Ernest Snider

14. MOTHER'S MAIDEN NAME Bessie May Colbert.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) W.W. I

16. SOCIAL SECURITY NO. None

17. INFORMANT Bryant Snider

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebro vascular Accident	8 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	10 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1948 to Jan, 1949, that I last saw the deceased alive on 2/6, 1949, and that death occurred at 4:30A m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M. Semonin M.D. 128 Upper St. Cumberland Allegany Md. 2/7/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/8/49	Zion Memorial Park	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 7, 1949	Winter K. Bantz, M.D.	John J. Hafer	Cumberland Md.

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FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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151

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; LENGTH OF STAY (In this place): 4 Days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; STREET ADDRESS (If rural, give location): 101 Charles St.,
3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Clay (Last) Sperry	4. DATE OF DEATH: (Month) (Day) (Year): 2- 10-1949
5. SEX: Male; 6. COLOR OR RACE: White; 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced; 8. DATE OF BIRTH: Sept. 22, 1876; 9. AGE last birthday: 72 yrs.; If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.: 4 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner; 10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines; 11. BIRTHPLACE (State or foreign country): Frostburg; 12. CITIZEN OF WHAT COUNTRY?: U. S.	
13. FATHER'S NAME: Joshua Sperry	14. MOTHER'S MAIDEN NAME: Dora Altmiller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If year, give war or dates of service); 16. SOCIAL SECURITY NO.	17. INFORMANT: Mr. Harry Sperry

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Gastric Carcinoma, insp.	18 mos.
Antecedent cause(s)	
Diseases or conditions, if any, giving rise to the above ceuse stating the underlying ceuse last (b)	
(c) 2° anemia	12 mos.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not releted to the disease or condition causing death. Chronic glomerulonephritis	?

19a. DATE OF OPERATION: June 1948	19b. MAJOR FINDINGS OF OPERATION: Carcinoma greater curvature of stomach, infilt. Colon. (Hayes)		20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Yeer) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/1, 1947, to 2/10, 1949, that I last saw the deceased alive on 2/10, 1949, and that death occurred at 3:55 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Frank T. Hanratty	59 E. Main St. Frostburg, Md.	2/12/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-13-1949	Eckhart Cemetery	Eckhart Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-12-49	Mrs. Nancy N. Roe	Jacob Hafer	Frostburg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
FEB 15 1949
BUREAU V. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 5 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 627 Fredrick St.	STREET ADDRESS (If rural, give location): 627 Fredrick St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): EMMA CORDELIA STONE	4. DATE OF DEATH (Month) (Day) (Year): February 17, 1949
5. SEX: f — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed — 8. DATE OF BIRTH: June 19 1859 — 9. AGE last birthday: 89 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife — 10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (State or foreign country): Tunelton W Va — 12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: James W Conn	14. MOTHER'S MAIDEN NAME: ~~[illegible]~~ Joan Bolyard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no — 16. SOCIAL SECURITY NO.: none	17. INFORMANT: daughter, Mrs. W. Clay Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) congestive heart failure — 1 year

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic heart disease — 1 year

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 30, 1948, to Feb. 17, 1949, that I last saw the deceased alive on Feb. 10, 1949, and that death occurred at 4 40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
L Brings MD	59 Greene St, Cumberland Md	2-17-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-19-49	Queen Point	Keyser Mineral W Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	21. FUNERAL DIRECTOR	ADDRESS
Feb 17, 1949	Winter R. Frantz, M.D.	N. Howard Rogers	Keyser W Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. T.

Within corporate DR. SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

421.1
92a

01282

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 317 GRAND AVE.,
(If rurol, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. VIOLA R. SWAIN

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife JOSEPH C. SWAIN

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) MARCH 11, 1901

8. AGE: Years	Months	Days	If less than one day
47	11	9	..... hrs. ..... min.

9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name GEORGE McABEE

13. Birthplace MARYLAND

MOTHER 14. Maiden name JEANETTE HERSHBERGER

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE.,

17. Burial Date thereof Feb. 11, 1949
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem

Location Cumberland, Md.

18. Funeral director James F. Scarpelli

Address Cumberland, Md.

19. Feb. 10, 1949 W. L. Lantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 9, 1949 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1949 to Feb. 9 1949 and that I last saw h.er alive on Feb. 9 1949

Immediate cause of death	DURATION
Cardiac Failure	48 hrs.
Due to Acute bronchopneumonia	1 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George M. Simons M. D. or other

Address 124 Union St Date signed 2/9/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
FEB 15 1949
BUREAU V. S.

Within corporate limits Dr. Durrett

01283

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

491

CERTIFICATE OF DEATH

107

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural, give location) Route 2, Williams Road

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) O'Lena	(Last) Twigg	4. DATE OF DEATH	(Mouth) February (Day) 6 (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4-13-1898	9. AGE last birthday 50 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John R. Kline		14. MOTHER'S MAIDEN NAME Clara Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT Memorial Hospital, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broncho-Pneumonia	2 days
Antecedent cause(s)	(b) Myocarditis	8 hrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 5, 1949, to Feb. 6, 1949, that I last saw the deceased alive on Feb. 5, 1949, and that death occurred at 6:50 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clay J. Durrett	M.D.	Cumberland	[illegible]

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 8, 1949	Mt. Herman Cem	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 8, 1949	Winter K. Frantz M.D.	John J. Hafer	Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. S.

Outside of City Limits

01284

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

919.0
184

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY Allegany MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland Md. LENGTH OF STAY (in this place) life HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.3 Hazen Road	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Pa. COUNTY Bedford CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland Md. STREET ADDRESS (If rural, give location) R.F.D 3 Cumberland Valley ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William Harrison		Twigg	Feb.	16	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
male	white	married	Jan.14-1928	21 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S.Army & farm laborer	farm	Cumberland Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Twigg	Daisy Belle Kieffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes		213-22-1011	Mrs.James Twigg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary & abdominal hemorrhage	about 5
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) 12 guage shotgun wound in right side of	minutes
	(c) chest entending in abdomen.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE accident	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY father's home	(CITY OR TOWN) Rural	(COUNTY) Cumberland, Allegany	(STATE) Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work ☐	Not While At work ☒	HOW DID INJURY OCCUR?
Feb.16/49 noon			(?) From all indications Gun slipped after looking in barrel muzzle hit chest & it exploded.

22. I hereby certify that I attended the deceased from Feb. 16, 1949, to ----- ---, 19....., that I last saw the deceased alive on Feb. 16, 1949, and that death occurred at noon m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland Md.	Feb.16-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/19/49	Centenary	Near Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 19, 1949	Winter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

VS. A15

RECEIVED
FEB 22 1949
BUREAU T. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 46 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, giva location) 1115 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) Josephine (Last) Valentine

4. DATE OF DEATH (Month) Feb. (Day) 2 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
Female	White	Single	March 8 1902	46 yrs.				

10a. USUAL OCCUPATION (Giva kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Office manager	Food industry	Maryland	U S A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. T Valentine	Nettie E Brant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		214-05-4253	Miss Erma Valentine

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intestinal Obstruction	5 days.
Antecedent cause(s)	(b) Carcinoma of Splenic Flexure Colon.	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Toxemia	6 days.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to tha disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-31-49	Obstruction Colon	Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-31-49 19....., to 2-2-49 19....., that I last saw the deceased alive on 2-2-49, 19....., and that death occurred at 2 50 pm m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C R Zimmerman	Mb.	Cumberland Maryland	2-3-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 5 49	Hillcrest Burial Park	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 5, 1949	Winter R. Lantz, M.D.	Louis Stein Inc	Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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FEB 10 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

01286

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 40 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 414 Bedford St	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 414 Bedford St

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Ralph	Richard	Walton	Feb	2	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	March 17, 1880	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Orthopedic Machine	Shoe + Braces	Lancaster Co Pa	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Chas Walton	Catherine Smeltzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	Spanish American	None	Annie Paul Walton (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	12 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension - Asthma	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic myocarditis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1945, to Feb, 1949, that I last saw the deceased alive on 2/2, 1949, and that death occurred at 2/2/49 m., from the causes and on the date stated above.

SIGNATURE John R. Rowen (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 4/3/49.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 5 1949	Hillcrest Burial Park	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 5, 1949	Winter K. Frantz, M.D.	Louis Stein	"

VS. A15

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FEB 10 1949
BUREAU V. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 Grand Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 9 Grand Ave

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Hannah (Last) Whetzel

4. DATE OF DEATH (Month) Feb. (Day) 13 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Sept. 16, 1867
9. AGE last birthday 81 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Paw Paw W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Asa Lewis
14. MOTHER'S MAIDEN NAME Elizabeth Moreland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Gilbert Whetzel (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	10 yrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteria sclerosis	15 yr.
	(c) None	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-25, 1949, to 2.13, 1949, that I last saw the deceased alive on 2.17, 1949, and that death occurred at 2 45 A m., from the causes and on the date stated above.

SIGNATURE H. A. Gleason M.D. (Degree or title) 126 Yearn St, Cumberland Md ADDRESS H. A. Gleason M.D. DATE SIGNED 2/14/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-15-49
NAME OF CEMETERY OR CREMATORY Rose Hill Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Feb. 15, 1949
REGISTRAR'S SIGNATURE Walter R. Dantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumb'd Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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FEB 28 1949
BUREAU V. S

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Pennslyvania COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 3 Weeks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bedford
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 460 West Pitt Street ✓

3. NAME OF DECEASED (Type or Print)	(First) Anna	(Middle) Regina	(Last) Will	4. DATE OF DEATH	(Month) 2	(Day) 7	(Year) 1949
5. SEX ~~Female~~	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 9/7/1879	9. AGE last birthday 68 yrs.	If under 1 year Months. 5	Days 0	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Chain Stores	11. BIRTHPLACE (State or foreign country) Bedford Penna.			12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Henry Will			14. MOTHER'S MAIDEN NAME Mary Leasure				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY No. 209-03-2467	17. INFORMANT Ernestine Messman				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Thrombosis — 2 wks

Antecedent cause(s) (b) Arterio Sclerosis — Unknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arthritis — Unknown

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 21, 1949 to Feb 7, 1949, that I last saw the deceased alive on Feb 7, 1949, and that death occurred at 8:50 a.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) [signature] ADDRESS 40 Decatur St Cumberland Md DATE SIGNED 2/7/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/10/49	NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	LOCATION (City, town, or county) Bedford	(State) Pa
DATE REC'D BY LOCAL REG. Feb. 8, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR Alton Barefoot	ADDRESS Bedford, Pa.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH 164 C

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
STATE: MARYLAND
LENGTH OF STAY (in this place): Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.1 Homewood Addition

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN: ~~R.F.D.#1 Homewood Addition~~ Cumberland, Md. Rural
STREET ADDRESS (If rural, give location): R.F.D. #1, Homewood Addn

3. NAME OF DECEASED (Type or Print): (First) Andrew David (Middle) (Last) Wolford

4. DATE OF DEATH: (Month) Feb. (Day) 4 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Aug.12-1878

9. AGE last birthday: 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farm laborer

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Wolford

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-2001

17. INFORMANT: son) George E.Wolford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Intra-abdominal hemorrhage	at once
Antecedent cause(s)	a self inflicted shotgun wound in abdomen	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Suicide

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home (CITY OR TOWN): Rural (COUNTY): Cumberland (STATE): Allegany Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Feb.4-49 about 9 p. m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? A self inflicted shotgun wound.

22. I hereby certify that I ~~attended~~ the deceased ~~from~~ Feb.5....., 1949., to ----------, ~~19~~ ....., that I last saw the deceased alive on Feb.5....., 1949 and that death occurred at about 9 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H.V.Deming M.D. H.V. Deming M.D.

ADDRESS: Cumberland Md.

DATE SIGNED: Feb.5-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Feb. 8th'49

NAME OF CEMETERY OR CREMATORY: Zion Memo.Cem

LOCATION (City, town, or county) (State): Rt. 220 Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 8, 1949

REGISTRAR'S SIGNATURE: Winter L. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc.

ADDRESS: Cumberland, Md. Feb.8'49

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Virginia COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Points
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED (Type or Print) (First) JOANN (Middle) ARBUTUS (Last) WOLFORD

4. DATE OF DEATH (Month) February (Day) 28, (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Oct. 24, 1948

9. AGE last birthday yrs. If under 1 year Months 4 Days 4 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Points, West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Roy W. Wolford

14. MOTHER'S MAIDEN NAME Frances Zirk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mr. Roy W. Wolford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) acute laryngotracheobronchitis — INTERVAL BETWEEN ONSET AND DEATH: one week

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. malnutrition

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/27, 1949, to 2/28, 1949, that I last saw the deceased alive on 2/28, 1949, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE Felix Springs (Degree or title) M.D. ADDRESS La Vale, Md. DATE SIGNED 3/1/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF March 2, 1949

NAME OF CEMETERY OR CREMATORY Wesley Chapel

LOCATION (City, town, or county) (State) Points, West Virginia

DATE REC'D BY LOCAL REG. March 1, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR W. H. McKee, Augusta, West Virginia ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 7 1949
BUREAU V. S.

Within corporate limits

DR. W.F.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

332 01292

CERTIFICATE OF DEATH

83E Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 1DAY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LONACONING
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location) ROCKVILLE ST.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HENRY	W.	WORGAN	FEB.	25,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	WHITE	MARRIED	8/19/79	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mining Retired	Coal Mines	MARYLAND	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HUBERT WORGAN	[redacted] Rebecca Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Thrombosis	Very Short time.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arteriosclerosis	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2-24, 1949, to 2-25, 1949, that I last saw the deceased alive on 2-24, 1949, and that death occurred at 7:14 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. F. Williams	M.D.	Cumberland	2-25-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 28, 1949	Fillerest Burial Park	Cumberland,	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 28, 1949	Walter R. Frantz, M.D.	M. Eichhorn,	Lonaconing, Md.

VS. A15

RECEIVED
MAR 7 1949
BUREAU V. S.

DR. WILSON
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

904.0 01293
156a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (In this place): 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FRANKLIN
STREET ADDRESS (If rural give location): 1 mi N of Westernport, Md

3. NAME OF DECEASED (Type or Print): (First) HOWARD (Middle) C. (Last) Yerger [redacted]

4. DATE OF DEATH: (Month) Feb. (Day) 14 (Year) 19 49

5. SEX: MALE

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8/23/1866

9. AGE last birthday: 82 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer-Retired

10b. KIND OF BUSINESS OR INDUSTRY: Coal mine

11. BIRTHPLACE (State or foreign country): Bellefonte, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: 212-18-1057

17. INFORMANT: L. S. Snyder [redacted] Yerger

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Subarachnoid hemorrhage, diffuse — about 6 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Fell and hit the back of his head. Contussion of the brain.
(c) general arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home — (CITY OR TOWN): Franklin — (COUNTY): Allegany — (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Feb. 6, 49 m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?: Fell & hit the back of his head.

22. I hereby certify that I ~~attended~~ saw the deceased from Feb. 14, 1949, to ----------, 19--, that I last saw the deceased alive on Feb. 14, 1949, and that death occurred at 7.25 P. m., from the causes and on the date stated above.

Dead

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. V. Deming M.D	H. V. Deming M.D	Cumberland Md.	2.15-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/18/49	St Peters Cem.	Westernport	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 17, 1949	Walter L. Frantz M.D.	Clement L. Beal	

Deputy Medical Examiner Allegany Co

RECEIVED
FEB 22 1949
BUREAU V. S.